UNITED NATIONS

E

Economic and Social Council

Distr.
LIMITED

E/ICEF/1992/P/L.3
21 February 1992

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Programme Committee
1992 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Lesotho

The Executive Director recommends that the Executive Board approve the country programme of Lesotho for the period 1992 to 1996 in the amount of $5 million from general resources, subject to the availability of funds, and $7,664,000 in supplementary funds, subject to the availability of specific-purpose contributions.

CONTENTS

	Page
THE SITUATION OF CHILDREN AND WOMEN	2
PROGRAMME COOPERATION, 1987-1991	6
RECOMMENDED PROGRAMME COOPERATION, 1992-1996	9

List of tables

1.	Basic statistics on children and women	15
2.	Expenditure under previous cooperation period, 1987-1991	17
3.	Planned expenditure, 1992-1996	18
4.	Staffing from budget and programme funds	19

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1991, will be contained in the "Summary of 1992 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.2 and Add.1).

92-07896 2992g (E) 080492 100492

/...

THE SITUATION OF CHILDREN AND WOMEN

1. Lesotho has a population of 1.8 million people, 86 per cent of whom live in rural areas. Arable land is scarce, comprising a mere 227,000 hectares. Agriculture, the major sectoral activity, accounts for a declining 20 per cent share of the gross domestic product. The country has a high total fertility rate (5.8 per cent), which is the result of early marriage, increasing premarital sexual activities, limited knowledge and use of contraceptives, reduced male labour opportunities in South Africa, improved medical services and an increasingly youthful population. In 1986, children up to the age of 14 accounted for 40.7 per cent of the total population. Based on the current annual growth rate of 2.6 per cent, Lesotho's population will reach an estimated 2 million in the year 2000.

2. For the past 15 years, Lesotho's national income has been dependent on South Africa in the form of remittances by an estimated 120,000 Basotho migrant workers. In 1989, these mine workers earned roughly $400 million in wages. Of this, about $100 million returned to Lesotho in the form of deferred pay, and $75 million in the form of remittances. Additional income in 1988/89, amounting to $69 million, came from common customs union revenue. The economy is extremely vulnerable to external factors, and the country is now experiencing a falling rate of agricultural production and an increasing rate of closure of both industrial and commercial establishments. Unemployment in 1990/91 is estimated at 41 per cent. By end of 1991, some 80,000 Basotho miners in South Africa are to be retrenched. In 1988, the Government and the International Monetary Fund (IMF) agreed upon the introduction of a structural adjustment programme, which called for adjustments to the national budget, a reduction of subsidies and tax increases. One of the measures taken to reduce subsidies was to increase levels of cost-recovery in government services, resulting in large increases in user charges for health, electricity and water services. The immediate effect of this measure at government health facilities was an overall reduction in attendance, including that of children under five years of age.

3. An analysis of data from surveys and a poverty mapping exercise reveal that Lesotho is facing increasing levels of poverty over time. The distribution of primary resources, such as land for agriculture, livestock, income and migrant remittances, is heavily skewed in favour of either a few households or those in lowland towns. There are no accurate statistics available of people who live on the margin of poverty, but available evidence suggests that the number is large, especially in the mountain and foothill areas. This poses serious implications for the survival and development of children and other vulnerable groups.

4. Available mortality and morbidity data in Lesotho are based on data from health facilities, but for as many births that are registered, a large percentage of total births are not registered. The infant mortality rate (IMR) is estimated at 95 per 1,000 live births, and the under-five mortality rate at 130 per 1,000 live births. Available data for 1988 show that

diarrhoeal diseases remained the leading direct cause of infant and child mortality, at 38 per cent and 32 per cent, respectively. Other causes include acute respiratory infections (ARI), low birth weight, nutritional deficiencies, accidents involving burns and food poisoning. The inadequacy of the registration system for vital statistics also necessitates that the maternal mortality rate (MMR) must be calculated from institutional data. Most women who give birth at hospitals are high-risk cases referred by village health workers (VHWs), traditional birth attendants (TBAs) and health centre staff. Eighty-five per cent of pregnant women attend antenatal clinics, but few deliver in hospital. Available 1988 institutional figures estimate that MMR was 220 per 100,000 live births. Among recorded cases, the main causes of maternal mortality are haemorrhage, sepsis and prolonged labour. It is difficult to determine the extent of maternal morbidity in Lesotho because of the weak health information system. Twenty-six per cent of all out-patient visits to health facilities indicate that respiratory diseases are the leading cause of morbidity. Sexually transmitted diseases (STDs) are the leading communicable diseases. The incidence rates of gonorrhoea and syphilis are 16 and 6 per 1,000 persons, respectively.

5. Many factors contribute to inadequate household food security in Lesotho. Sixty per cent of the male population work in mines, primarily in South Africa, and are not present for farming and food production activities. Twenty-five per cent of female-headed households are without farming plots and 20 per cent are without remittances from mines. Female-headed households where the women are engaged in farming are unable to obtain financial credit because of women's legal status as minors. Malnutrition is a major contributory factor to maternal, infant and child morbidity and mortality. The 1991 situation analysis of children and women reveals that the malnutrition rate as determined by weight-for-age for children one to two years old averaged 29 per cent, and for children 2 to 4 years old, 23 per cent. Low birth weight averaged 13 per cent. Malnutrition contributed to 39 per cent of IMR and 45 per cent of child mortality in 1988. Studies show that the major causes of malnutrition are the early introduction of sugared water, the predominant use of commercial milk substitutes and a lack of energy-dense food in children's diets. The lack of food and women's lack of time to feed and care for their children also contribute to childhood malnutrition. Infrequent feeding of the majority of 4- to 36-month-old children increases their susceptibility to malnutrition. Additionally, during episodes of diarrhoea and vomiting, food is usually withdrawn. Iodine deficiency is a contributory factor in maternal malnutrition. Studies show that the incidence of iodine deficiency varies from 14 to 45 per cent among women of child-bearing age and 6 to 39 per cent among schoolchildren. The prevalence of endemic goitre appears to be higher in mountain areas.

6. Studies show that 45 per cent of the population in rural areas have access to safe water supplies and 14 per cent to sanitary means of excreta disposal, as compared to 59 and 22 per cent, respectively, for water supply and sanitation facilities in urban areas. Contaminated water, particularly in rural areas, comes from sources such as unprotected springs, rivers and dams, and transmits gastro-intestinal diseases such as typhoid, diarrhoea and

worms. As a result of inadequate sanitation, diarrhoeal diseases remain the principal cause of morbidity and mortality among young children and a major cause of morbidity among adults nationwide.

7. Lesotho is divided into 18 geographic health service areas, structured around the nine existing government hospitals and nine church hospitals, the latter falling under the Private Health Association of Lesotho (PHAL). A nineteenth health service area was structured around remote mountain health facilities and is supervised by the Lesotho Flying Doctors' Service. Although there is at least one hospital for every district in Lesotho, these facilities are mainly concentrated in the lowlands. The number of health centres has been increasing steadily in recent years, although constraints now imposed by the structural adjustment programme severely limit the rate of expansion. Bad roads, rugged terrain and a lack of bridges make it difficult to establish new facilities or to run existing ones efficiently in sparsely populated mountain areas. As a result, people in many of these communities walk long distances to the nearest health facility. More than 50 per cent of both government and PHAL hospitals and health centres are either poorly housed or in a poor state of repair. The structural adjustment programme and its accompanying austerity measures, together with the general budgetary crisis of PHAL institutions, make it difficult to identify, engage and retain qualified staff in the health sector. The lack of adequate accommodations and relatively more attractive salaries and working conditions in South Africa have been cited as additional constraints to adequate staffing. In addition to the Government-PHAL dichotomy in staffing, there is also a regional variation, whereby most of the health personnel are concentrated in the lowlands. This skewing is viewed as counter-productive in terms of the Government's objective of equity in the distribution of health care.

8. Educational development since independence has been rapid, and school enrolment rates have greatly increased. The net primary school enrolment ratio in 1989 was 55 per cent of children 6 to 12 years of age. Sixty per cent of pupils at the primary level are female. Adult (15 years old and above) literacy is estimated at 62 per cent. However, the existing system of education suffers from critical problems, such as inefficiency and decline in quality and relevance to the occupational and socio-economic realities of Lesotho. The system is characterized by high wastage, drop-out and repetition rates, weak management and inadequate teaching and learning materials and facilities, especially at the primary level. The low completion rate is particularly worrying at the lower primary school level. The reasons for this include overcrowded classrooms and lack of essential facilities (14 per cent of the pupils are without classrooms, 40 per cent without desks and chairs and 70 per cent with very poor sanitation facilities); a high proportion of over-age pupils (70 per cent of class 1); unqualified teachers (19 per cent); and lack of adequate and appropriate teaching/learning materials. The average pupil-teacher ratio in 1988 was 56 to 1. The annual drop-out rate between 1988 and 1990 was estimated at 8 per cent. In short, the education system fails to prepare enough children with the practical and technical skills and knowledge needed for Lesotho's economic development or for productive and progressive lives. With regard to adult literacy, studies show that about

50 per cent of adults are functionally illiterate. It is estimated that 54 per cent of males and 70 per cent of females are literate. Herd-boys and returned mine workers constitute the largest groups of functional illiterates.

9. Early childhood development (ECD), a relatively new area for Lesotho, is mainly a community-based activity supported by non-governmental organizations (NGOs). There were approximately 800 ECD centres of all types and sizes in 1989, providing care and education for about 10,000 children between two and five years of age, which represents about 4 per cent of the relevant age group. Coverage is much lower in rural areas. The increase in number of ECD centres from 200 in 1985 to 800 in 1989 is a clear reflection of growing community interest and commitment. With the growing economic constraints experienced by Lesotho, an increasing number of working mothers, particularly single parents, require safe and environmentally stimulating centres for child care. In addition, many parents now see the importance of ECD as preparation for primary schooling.

10. Statistics are generally unavailable on the extent of the problem of children in especially difficult circumstances. However, police records and available studies signal cause for concern. The number of abandoned children in Lesotho is unknown, since the majority of these cases go unreported. There are no accurate statistics on disabled and street children, although it is estimated that these issues are becoming a real problem. Few institutions cater to disabled or socially disadvantaged children, and facilities and care vary. Another vulnerable group are the herd-boys, who are often the victims of natural disasters and are deprived of educational opportunities. These children begin their work in this traditional way of life as early as eight years of age.

11. The prolonged absence of the majority of males in the mines and farms of South Africa makes the role of women, both in the family and in the economy, critically important in the advancement of child survival, protection and development. Under current legislation, the rights of women are limited. Women are legally classified as minors, a situation that continues to retard women's development severely, leaving them without the social, political and economic benefits that fair and just legislation should provide. Further worsening this situation, cultural stereotypes, ignorance of the law and confusion regarding the dual system of law (Roman-Dutch and customary law) have created for the majority of women a certain acceptance of the status quo. Constraints women face include limited legal rights, negative traditional attitudes, lack of access to credit and an overload of domestic duties.

12. Lesotho faces enormous difficulties in social communication with remote places in the country because of the rugged terrain. The problem is exacerbated by sharp socio-economic differences between the lowland and mountain regions. For example, although nationwide household radio ownership in 1987 was 62 per cent, only 20 per cent of households in the mountain areas owned radios. In addition, the circulation of newspapers and other print materials in the mountain regions is also limited.

PROGRAMME COOPERATION, 1987-1991

13. UNICEF cooperation for the period 1987-1991 aimed at (a) the attainment of 90 per cent immunization coverage by 1990 and an increase in antenatal care attendance to 85 per cent; (b) the provision of effectively trained, supervised and equipped VHWs to promote community health activities in all villages in Lesotho, thus increasing coverage for antenatal care, immunization, oral rehydration therapy, growth monitoring and other family health measures; (c) the reduction of the prevalence of malnutrition in children under 24 months of age from 30 to 15 per cent, and the reduction of the hospitalization rate of under-five-year-olds due to malnutrition by 50 per cent from 1985 levels; (d) an increase in access to ECD centres of Basotho children aged two to six years to 50 per cent and a reduction in hospital morbidity due to accidents among children aged one to four years by 25 per cent; and (e) a significant increase in support, demand and knowledge with regard to the core programmes of child survival, protection and development and maternal health.

Health

14. The health programme took note of the Government's adoption of primary health care (PHC) as the strategy for providing basic health care for all, with a greater emphasis placed on preventive services. By 1988, full immunization coverage had increased to over 60 per cent, from 40 per cent in 1982. A survey revealed that, by 1990, universal child immunization (UCI) targets had been achieved despite many constraints. Significant progress has been made in the strengthening of family health services through the development of managerial processes and support systems. The cold-chain system is adequately equipped and functions with a high degree of reliability. Training for supervisors, technicians and health workers was intensified based on the assessment of needs derived from programme evaluation at health service area and national levels. A significant reduction has been seen in the number of measles cases, which has dropped from over 8,000 in 1981 to about 1,500 in 1989. Over the past 10 years, the prevalence of lameness attributable to polio has dropped from 250 to 23 per 100,000 cases for children aged five to nine years. The Government began a national control of diarrhoeal diseases (CDD) programme in 1983, under the Combating Childhood Communicable Diseases project supported by the United States Agency for International Development (USAID). The CDD programme aimed at training health centre staff, VHWs and parents in the recognition and management of cases of diarrhoea. UNICEF contributed to the CDD programme through the provision of oral rehydration salts, training of health staff and production of suitable health education materials. The programme emphasized improved case management and prevention, including promotion of breast-feeding, improved weaning practices, improved hygiene practices, use of clean water and improved sanitation facilities.

Training of community health workers

15. The training of community health workers (CHWs) received major support during the programme period. The findings of a 1988 programme evaluation revealed a good distribution of VHWs, who were also found to be active and competent; community involvement and participation; promotion of latrine construction and spring protection; and extensive collaboration between the Government, NGOs and individuals. Further studies revealed that the successful training of CHWs has contributed to increases in the following: immunization coverage, to over 60 per cent; the correct treatment of diarrhoea, to 32 per cent; use of antenatal care services, to 85 per cent; and use of delivery services, to 60 per cent. Improvements in growth monitoring, increased dissemination of information on the importance of clean water and sanitation and involvement of communities in health activities were also noted. A total of 5,800 VHWs and 1,200 TBAs have been trained. Standardized training manuals have been developed for both categories of health workers.

Nutrition

16. The nutrition programme focused on the two districts worst hit by malnutrition, Qacha's Nek and Quthing. A unified growth chart was developed; nutrition education supported by appropriate material and training of trainers was provided for improved management of the project; intensive community-based growth monitoring on a monthly basis was introduced in 21 areas in the two districts; training in growth monitoring, weaning practices and other health issues was given to extension workers; and intensive support was provided for committees established at central, district and area levels. Much attention has been given to intersectoral collaboration. The household food security component aimed at ensuring that sufficient, appropriate food was produced and available. Income-generating activities for families which had no opportunity to participate in food production were supported. However, this component lagged behind because of a number of constraints, including limited technical capacity in the Government and in UNICEF, which resulted in a gradual but slow understanding and appreciation of the integrated approach to nutrition. However, there is evidence that communities are highly mobilized to participate in these activities.

Early childhood development

17. Through consultancies and workshops, the ECD programme has made a significant contribution to the formulation of government policy encompassing special education. An ECD Unit was established in the Ministry of Education and a curriculum developed for the training of ECD teachers. In addition, approximately 800 ECD centres were established, 581 of which were registered and manned by trained staff.

18. Posters, radio messages, travelling theatre, lectures and pitsos (public gatherings) were used to mobilize support and knowledge about the child survival, protection and development programmes, particularly in rural communities. Several studies and seminars advancing child survival themes

contributed significantly to national planning and policy formulation. On the tenth anniversary of the International Year of the Child, a national children's conference was held; the Declaration and Plan of Action of the World Summit for Children was signed by the Government; the United Nations Convention on the Rights of the Child was signed; the Jomtien Declaration on Education for All has set a clear path for government policies in education; and the United Nations Convention on the Elimination of All Forms of Discrimination against Women was signed.

Monitoring and evaluation

19. External and internal evaluations included assessments of the cost-effectiveness, coverage and impact of immunization; the impact of health and nutrition interventions; the effectiveness of the care and education of young children; the effectiveness of integrated training of health workers; and the impact of health education on various interventions. Knowledge, attitude and practice (KAP) studies were also carried out in various sectors, including health, and the effectiveness of social mobilization strategies was assessed.

20. While there were impressive successes in implementation, there were also a number of drawbacks, including overly ambitious targets for the various interventions; lack of analysed data for proper planning; thinly dispersed government staff; lack of clearly defined roles at the level of implementation; weak coordination and problems in establishing working administrative and accounting systems; low levels of involvement of health service area staff in the planning process; and unclearly specified government contributions. Emphasis, therefore, will have to be put on the following: strengthening coordination; providing increased support to national capacity building in policy formulation, planning, management, monitoring and evaluation; and improving information collection, analysis and use. There were a number of problems related to the quality of health statistics, which will need to be rectified. It was not possible to develop performance indicators to monitor the impact of various programmes in all health service areas or to target development assistance.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: $5,000,000
Supplementary funding: $7,664,000

Recommended programme cooperation a/
(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	2 438	2 749	5 187
Nutrition and household food security	618	2 184	2 802
Education	704	2 264	2 968
Social mobilization	590	282	872
Planning and social statistics	650	185	835
Total	5 000	7 664	12 664

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme preparation

21. The preparation of the 1992-1996 programme brought together government and United Nations agencies, NGOs and UNICEF representatives in a participatory planning process. Linkages were made with the goals of the 1990s as expressed in the World Summit Declaration and Plan of Action. A mid-term review held in 1989 identified previous programme constraints and made suggestions for improvement in implementation of the 1992-1996 programme. The 1990 situation analysis of children and women provided data to identify specific priorities and activities. A 1990 evaluation of the programme examined both overall and programme-specific impact in detail and identified a number of areas for close examination in terms of the design and implementation of the future programme. A strategy meeting drew together senior officials of government and United Nations agencies, the donor community, NGOs and the university to discuss the situation analysis, identify goals and objectives and map out programme areas and strategies.

Country programme goals and objectives

22. The programme of the Government and UNICEF for the period 1992-1996 clearly encompasses the framework of wider national efforts towards the achievement of the goals for children in the 1990s. The UNICEF-assisted

programme will link closely with and contribute to the preparation, implementation and monitoring of the Government's national programme of action for children, focusing on the goals for children considered especially urgent in Lesotho, in the light of the priority problems faced by women and children. The programme will also respond to the needs of the various sectors accorded priority for national development by the Government, namely, health, nutrition and household food security, education, community mobilization and national capacity building. Programme objectives have been formulated to support the Government's efforts to realize its goals and objectives of improving the well-being of children, women and other vulnerable groups.

23. The Government's major programme goals for the period 1992-1996 are the reduction of IMR from 95 to 50 per 1,000; the reduction of the under-five-year-old mortality rate (U5MR) from 130 to 70 per 1,000; the reduction of MMR from 220 to 146 per 100,000; the reduction of malnutrition among children under five years of age from 17 to 11 per cent; the expansion of ECD activities; the improvement of access to basic education and completion of primary school by at least 80 per cent of primary schoolchildren; the reduction of the adult illiteracy rate, with an emphasis on males, because of the unique situation in Lesotho, where the female literacy rate is higher than that of males, from 38 to 19 per cent; and the improvement of the situation of children in especially difficult circumstances.

Strategies

24. The programme will focus on strengthening the national capacity to plan, implement, monitor and evaluate programmes aimed at promoting the survival, protection and development of children. Emphasis will be placed on preventive and promotive measures that involve the mother and child, family and the community. Decentralized and integrated approaches will be supported for health service delivery, with a focus on the community level. Community participation in the planning, financing, and delivery of basic health services will be promoted, using the Bamako Initiative strategy. Advocacy for household food security will aim at improving the nutritional status of women and children. The status of women will be enhanced by advocating for a change in their current legal status as minors and promoting income-generating activities. A major strategy will be institution strengthening and national capacity building, aimed at ensuring the sustainability and expansion of child survival interventions at community and national levels. Social mobilization will promote the effective participation of all levels of society in the improvement of the status of women and children.

Health

25. The overall objective of the health programme is to improve the health status of children and women in Lesotho by strengthening PHC activities and sustaining achievements in UCI, which will consequently ensure the reduction of maternal, infant and child morbidity and mortality rates. The specific objectives are: (a) to reduce maternal mortality by strengthening antenatal and perinatal care and health service delivery, supporting operational

research to determine the causes and magnitude of maternal morbidity and mortality, improving health service delivery and training health workers in the identification of high-risk mothers, management and supervision; (b) to sustain a minimum antigen coverage of 90 per cent among children and achieve 80 per cent tetanus toxoid coverage among women of child-bearing age by supporting the training of health workers, logistical management and supervision, the expansion of health services to remote areas and the provision of vaccines and cold-chain equipment; (c) to increase the rate of diarrhoea cases treated correctly from 36 to 50 per cent; and (d) to reduce diarrhoea case fatality rates from 5 to 2 per cent and reduce the total number of diarrhoea cases by 30 per cent. Links between CDD and rural water supply and sanitation efforts will be reinforced through the development of training programmes that include both health and water supply and sanitation staff; the preparation of suitable hygiene education materials; and the coordination of activities through joint monitoring and evaluation. Existing district and village health coordination committees will be expanded to include all departments involved in rural water supply and sanitation activities.

26. Other objectives include: (a) the reduction of deaths from pneumonia among children up to four years old by 50 per cent through the rational use of antibiotics; (b) the correct assessment and treatment of ARI through the provision of training in case management and support for materials development, health education and immunization to prevent respiratory infections among children; and (c) the prevention and control of the spread of the human immune deficiency virus (HIV) and STDs and the limitation of the social and health consequences of HIV/acquired immune deficiency syndrome (AIDS) through support for the training of health workers, community leaders and women's groups, emphasizing health education in secondary schools and supporting research to determine the impact of HIV infection on the prevalence of tuberculosis. Since the structural adjustment programme may impose both positive and negative effects on different segments of the population, particularly communities that are already burdened by economic and social difficulties, the 1992-1996 programme aims at putting mechanisms in place for strengthening and sustaining PHC at district, health service area and community levels in order to reach large segments of the population currently under-served.

27. The health programme will also strengthen the capacity of the Ministry of Health to implement PHC programmes efficiently and effectively by generating community support for health financing. This will be achieved by implementing the Bamako Initiative strategy to revitalise the health system. That strategy will thus become the core of the health programme as a means of extending accessibility to sustained PHC and ensuring communities' involvement and participation in health services. While ultimately attempting to strengthen all health service areas initially, programmes will first be intensified in five areas. CHWs will be trained, supervised and equipped with the necessary supplies to provide services in all communities by health service area trainers, nurse clinicians and central level staff, who receive continuous training in all elements of PHC, including HIV/STD control. The Ministry of Health and PHAL will be strengthened to plan effectively and implement PHC

programmes through the integration of health services and the extension of PHC services to under-served and remote areas of the country. Support will be provided for village health posts, transportation, supervision of remote mountain-based health facilities and decentralization of the health information system to four districts/health service areas.

Nutrition and household food security

28. The overall objective of the nutrition and household food security programme is to improve the nutritional status of women and children by reducing severe and moderate malnutrition among children up to five years old by 1996 by one third of its 1990 level. Specific objectives include increasing the rate of growth monitoring among children up to 5 years old by 30 per cent; ensuring that at least 80 per cent of mothers understand the importance of growth monitoring and that 65 per cent can correctly interpret the growth curve; increasing the rate of exclusive breast-feeding for the first four months of life by 10 per cent; ensuring that 60 per cent of mothers wean their children (4-24 months of age) on local high-energy-dense food; and reducing the prevalence of bottle feeding from 80 to 40 per cent. The programme will ensure that initial training and refresher courses in growth monitoring and weaning are integrated into CHW training and other health programmes. Support will also be given for the training of extension and health facility workers, the development of growth-related nutrition messages and the dissemination of these messages through women's groups and the mass media. Growth monitoring equipment will also be provided.

29. The reduction of endemic iodine deficiency disorders (IDD) will be achieved through the training of health workers, advocacy for the sale and use of iodized salt and health education. This activity will benefit from a baseline survey in four ecological zones to determine the prevalence of IDD. Food accessibility will be improved by promoting drought-resistant crops, home and communal gardens, labour-saving devices, simple technologies for food preservation and small-animal raising. The rate of low-birth-weight babies will be reduced from 13.5 to 5 per cent. Appropriate technology will be promoted and funds provided for seeds and education to ensure that 25 per cent of low-income households in six districts have increased income and access to food, and to ensure that 50 per cent of households without land participate in income-generating activities.

Education

30. The Government collaborated with the World Bank, the United Nations Development Programme (UNDP), USAID and UNICEF to develop its education sector development plan for 1991-1996. The two major objectives of the plan are to increase the quality, efficiency and relevance of education programmes at all levels of the education system, with a special focus on primary education, and to improve education management and address the financing and resource allocation issues which limit the development of the education sector as a whole. The objectives of the UNICEF-assisted programme are: (a) to improve substantially the quality of ECD, including special education; (b) to improve

access to and integration into the primary school system for children with disabilities; (c) to strengthen the teaching skills of primary schoolteachers in core curriculum subjects for classes 1 through 3 in order to improve pupils' learning achievements; and (d) to improve the literacy rate and educational opportunities of Basotho mine workers, herd-boys, out-of-school children and drop-outs through the provision of alternative learning opportunities to acquire basic education. Training, the development of education materials, social mobilization and the development of kits for young children will be the primary tools used to achieve the objectives.

Social mobilization

31. The objective of the social mobilization programme is to mobilize all levels of the society to participate in and promote the health, nutrition, education and legal rights of children and women, as well as their survival, protection and development within the context of national and social development. Media capacities to identify, analyse and solve child survival problems will be strengthened through social communications for development. The programme will support the training of various categories of personnel, exchange of information through networking, research and development in knowledge, attitude and practice (KAP) and the production of communication materials.

Planning and social statistics

32. The overall aim of the planning and social statistics programme is to support the country programme through surveys and the provision of relevant and timely information for proper planning and national capacity building to achieve the goals for children and development in the 1990s. Existing human and institutional resources at all levels within the country will be mobilized and strengthened. The National University of Lesotho and other institutions of higher learning will be linked with ongoing activities in an attempt to improve child survival, protection and development. Assistance will be provided to enable those responsible for the collection and analysis of data and information on children and women in Lesotho to monitor the effects of the programme interventions. The interventions will promote and support community involvement and responsibility, using the Bamako Initiative strategy. Academic training will be associated with community needs and priorities. Specific areas for study already identified include herd-boys, street children, children with disabilities, abandoned children and women with disabilities. The updating of the situation analysis will be an ongoing process for planning and programme reformulation.

Monitoring and evaluation

33. A system of regular reporting on programme and project progress will be followed by each responsible implementing partner. UNICEF will develop an integrated reporting system in cooperation with the Government. The system of annual review of the overall country programme will continue under the chairmanship of the Ministry of Planning, with the participation of the

concerned United Nations agencies and others. These reviews will form the basis of reformulation of the plans of action. Regular field visits will be undertaken jointly with government counterparts to allow close analysis of the progress of individual projects and to promote intersectoral coordination and participatory planning. Joint evaluation and assessment activities will be undertaken. A mid-term review of the programme, with accompanying evaluations, will be undertaken in mid-1994 to review overall trends and progress towards objectives and to reflect upon the effectiveness of strategies adopted. An overall research programme and database will be developed to facilitate programme development and monitoring and mid-term programme reformulation. The information will also be used to monitor and analyse progress towards the global goals for children and development in the 1990s.

34. A Government/UNICEF implementation framework has been developed, with clearly defined roles. The phasing of implementation with available managerial, technical and financial resources has also been defined in the country programme management plan. The structure of the country office has been adjusted to reflect the staffing needs of the new programme. A detailed fund-raising strategy has been formulated which takes into account the need for significant supplementary funding to achieve the programme objectives.

Coordination with other partners

35. The programme plans of operation were reviewed with the concerned United Nations agencies. These plans are complementary to the activities of the United Nations Development Programme (UNDP) (women in development, education and national capacity building); the World Health Organization (WHO) (essential drug supplies, training of health workers, health education and national capacity building); the United Nations Population Fund (UNFPA) (health and women in development); the World Bank (nutrition, household food security and education); USAID (education); the Swedish International Development Authority (national capacity building); and NGOs such as Rotary International (health), Plenty Canada (nutrition and household food security), the Bernard Van Leer Foundation (education) and Save the Children Fund (United Kingdom of Great Britain and Northern Ireland). Coordination with bilateral and multilateral donors will be undertaken through inter-agency meetings convened by the Ministry of Planning and sectoral ministries, as well as by the resident coordinator of the United Nation system.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Lesotho (1990 and earlier years) UNICEF country classification

Under-five mortality rate	130	(1990)	High U5MR
Infant mortality rate	95	(1990)	Very high IMR
GNP per capita	$ 470	(1990)	Low GNP
Total population	1774.0 Thousands	(1990)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1990
Births	(thousands)	46	55	62	72
Infant deaths (under 1)	(thousands)	6	6	7	7
Under-five deaths	(thousands)	8	9	9	9
Under-five mortality rate (per 1,000 live births)		185	161	145	130
Infant mortality rate (under 1) (per 1,000 live births)		135	117	106	95

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1981)	Moderate & severe	..	16
	Severe	..	2
Babies with low birth weight (%, 1979/1987)		15	11
% of primary school children reaching final grade (1980/1988)		27*	52

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1977)		93 / 89 / 76	../ ../ ..
Prevalence of wasting (%, 1981)		..	7
Prevalence of stunting (%, 1981)		..	23
Daily per capita calorie supply (% of requirements, 1979-1981/1988)		103	101
Food production per capita index (Index 1979-1981=100, 1980/1990)		98	76
Household expenditure (% of total income)	All food/cereals		../..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1988)			68
Access to health services	Total	..	80
(% of population, 1980/1985)	Urban/rural	../..	../..
Access to safe water	Total	14	48
(% of population, 1980/1988)	Urbnn/rural	37/ 11	59/ 45
Access to adequate sanitation	Total	14	15
(% of population, 1980/1985)	Urban/rural	13/ 14	22/ 14
Births attended by trained personnel (%, 1988)		..	40
Maternal mortality rate (per 100,000 live births, 1973)		1600	..

Immunization		1981	1985	1990
One-year-olds (%) immunized against:	Tuberculosis	81	86	97
	DPT	56	82	76
	Polio	54	80	75
	Measles	49	73	76
Pregnant women (%) immunized against	Tetanus	..	0	0

TABLE 1 (continued)

Lesotho

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	102/ 66	112/ ..
(%, 1980/1987)	Male	85/ 54	101/ ..
	Female	120/ 78	123/ ..
Secondary enrolment ratio (gross/net)	Total	17/ 13	25/ ..
(%, 1980/1987)	Male	14/ 9	20/ ..
	Female	20/ 16	30/ ..
Adult literacy rate, 15 years & older	Total	62	..
(%, 1970/1990)	Male/female	49/ 74	../ ..
Radio/television sets (per 1,000 population, 1980/1988)		22/0	68/1

DEMOGRAPHIC INDICATORS		1970	1980	1985	1990	2000**
Total population	(Thousands)	1064.0	1339.0	1538.0	1774.0	2370.0
Population aged 0-15 years	(Thousands)	..	590.2	688.2	802.9	1073.6
Population aged 0-4 years	(Thousands)	..	224.3	264.9	304.0	391.8
Urban population (% of total)		9	14	17	20	28
Life expectancy at birth	Total	47	52	55	57	62
(years)	Male	43	48	50	53	58
	Female	52	57	59	62	67
Total fertility rate		5.7	5.8	5.8	5.8	5.3
Crude birth rate (per 1,000 population)		43	42	41	41	38
Crude death rate (per 1,000 population)		20	15	13	12	9

		About 1980	Most recent
Contraceptive prevalence rate (%, 1977)		5	..
Population annual growth rate	Total	2.3	2.8
(%, 1965-1980/1980-1990)	Urban	14.6	6.8

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1990)		6.8	-0.9
Inflation rate (%, 1965-1980/1980-1989)		8	13
Population in absolute poverty (%, 1979)	Urban/rural	50/ 55	../ ..
Household income share (%)	Top 20%/bottom 40%	../ ..	../ ..
Government expenditure	Health/education	../ ..	7/ 16
(% of total expenditure, 1980/1987)	Defence	..	10
Household expenditure (% of total income, 1980-1985)	Health/education		../..
Official development assistance:	US$ millions	94	118
(1980/1989)	As % of GNP	15	14
Debt service (% of goods & services exports, 1980/1989)		1	3

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1991

(In thousands of United States dollars)

COUNTRY: LESOTHO
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $2,570,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	1054	796	283	73	222	350	269	290	1828	1509	3337
Water supply and sanitation	33						23	13	56	13	69
Nutrition	24	68	90	43		213	89	51	203	375	578
Education				2						2	2
Community organization and development		26		8			11	16	11	50	61
Young child development	2		3				23		28		28
Women-centred programme	32		12		22		7		73		73
Advocacy	3		36						39		39
Emergency		26					5		5	26	31
Planning and project support	62	7	48		206		203	2	519	9	528
Freight	142	23					6		148	23	171
GRAND TOTAL	1352	946	472	126	450	563	636	372	2909 a/	2006	4915

GR = General resources.
FSF = Funded supplementary funding.
a/ Including allocations to fund unfunded supplementary funds.

TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: LESOTHO Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	463	468	484	491	532	2438
	FSF	50					50
	NSF	707	744	499	427	372	2749
Nutrition and household food security	GR	150	129	114	115	110	618
	FSF	100					100
	NSF	488	463	423	400	410	2184
Education	GR	153	159	158	135	99	704
	NSF	588	550	405	367	354	2264
Social mobilization	GR	119	124	114	119	114	590
	NSF	124	91	37	14	16	282
Planning and social statistics	GR	30	30	30	30	30	150
	NSF	50	45	40	30	20	185
Programme support	GR	85	90	100	110	115	500
TOTAL	GR	1000	1000	1000	1000	1000	5000
	FSF	150					150
	NSF	1957	1893	1404	1238	1172	7664
GRAND TOTAL		3107	2893	2404	2238	2172	12814

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: LESOTHO	Number of posts	Amount (Thousands of United States dollars)
FINANCED FROM 1992-1993 APPROVED BUDGET:		
International Professional established posts	2	410
Local national Professionall and General Service established posts	6	199
Operating costs		298
Total	8	907
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	1	199
Supplementary funds	2	360
Local national Professionall and General Service project posts		
General resources	4	84
Supplementary funds	4	84
Total	11	727

a/ For information ssource, see the 1992 revised post authorization table, dated 23 July 1991.